Division of Human Resources

Compassionate Leave Program
PHYSICIAN'S STATEMENT FORM

Employee Name: _____ Employee ID: _____

☐ I certify that I am the patient or ☐ I certify that I am the patient's caregiver.

This section to be completed by patient prior to submitting to Physician

Patient's Name: _____

Address: _____

_____ Telephone No: _____

Patient's Signature Authorizing Release of Medical Information

Dear Doctor:

In order for Alachua County Public Schools to determine if the above referenced patient or patient's caregiver meets the criteria for the Compassionate Leave Program, we are requesting (with the patients consent) the following information:

Please describe the nature of the above-referenced patient's illness:

_____

_____

_____

What kind of treatment will the patient receive?

_____

_____

_____

How long do you expect the patient may need to be out of work?

_____

Additional Information:

_____

_____

_____

Physician's Name: _____

Signature: _____ Date: _____

Please return this form to: Personnel Services Department
(Attn: Compassionate Leave Program)
620 East University Avenue, Gainesville, FL 32601